TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
KILLEEN INJURY CLINIC

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-16-3184-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
June 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment was preauthorized. Per Benjamin with the carrier the claim continues to be denied stating a modifier is required. This procedure does not require a modifier; all other dates of service were paid correctly without any modifier on claims. I am requesting Medical Dispute Resolution to help resolve the dispute so bills can be paid correctly/timely."

Amount in Dispute: $177.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the Medical Dispute, the bills were sent for reconsideration. It was determined that no additional payment is due to the provider."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
November 25, 2015	90837	$177.30	$177.30

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 330 – CCI Comprehensive/Component procedure
   - 402 – The appropriate modifier was not utilized
   - ANSI236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier

Issues

1. Did the requestor bill in accordance with 28 Texas Administrative Code 134.203 (b)?
2. Did the requestor submit documentation to support that CPT Code 90837 rendered on November 25, 2015 was preauthorized?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT code(s) 90837 rendered on November 25, 2015. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) "330 – CCI Comprehensive/Component procedure" and "402 – The appropriate modifier was not utilized" and "ANSI236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier."

   28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules..."

   The Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

   The requestor billed CPT Codes 90837 and 90889 on November 25, 2015. Review of the NCCI edits indicate the following: "Per CMS guidelines, payment for procedure code 90889 is always bundled into payment for other services not specified and no separate payment is made."

   Review of the Table of Disputed Services, which identifies the services in dispute, does not identify CPT Code 90889 as a disputed service. The Division did not identify edit conflicts with CPT Code 90837, which is the disputed code. As a result, CPT code 90837 is reviewed pursuant to applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (7) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program."

   Review of the submitted preauthorization letter dated November 16, 2015 issued by MediCall finds the following:

Specific Treatment Plan Requested	6 sessions of individual psychotherapy between 11/11/2015 and 1/10/2016
UR Determination	The concurrent request for 6 sessions of individual psychotherapy between 11/11/2015 and 1/10/2016 is certified
Review Number	239028

   The requestor rendered CPT Code 90837 on November 25, 2015 within the preauthorized timeframes, as a result, the Division finds that the disputed service is therefore reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   28 Texas Administrative Code §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The MAR reimbursement for CPT Code 90837 is $197.00. The Requestor seeks $177.30, the lesser of is $177.30, therefore this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $177.30.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $177.30 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		July 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.